SECOND REGULAR SESSION

HOUSE BILL NO. 1918

98TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE GARDNER.

4928H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 334.035, 334.036, 334.037, and 334.038, RSMo, and to enact in lieu thereof one new section relating to the repeal of licensure of assistant physicians.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 334.035, 334.036, 334.037, and 334.038, RSMo, are repealed and one new section enacted in lieu thereof, to be known as section 334.035, to read as follows:

334.035. **[**Except as otherwise provided in section 334.036,**]** Every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule.

[334.036. 1. For purposes of this section, the following terms shall mean:

(1) "Assistant physician", any medical school graduate who:

(a) Is a resident and citizen of the United States or is a legal resident alien;

(b) Has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination within the two-year period immediately preceding application for licensure as an assistant physician, but in no event more than three years after graduation from a medical college or osteopathic medical college;

(c) Has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

two-year period unless when such two-year anniversary occurred he or she was serving as a resident physician in an accredited residency in the United States and continued to do so within thirty days prior to application for licensure as an assistant physician; and

(d) Has proficiency in the English language;

(2) "Assistant physician collaborative practice arrangement", an agreement between a physician and an assistant physician that meets the requirements of this section and section 334.037;

(3) "Medical school graduate", any person who has graduated from a medical college or osteopathic medical college described in section 334.031.

2. (1) An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physicians may practice.

(2) For a physician-assistant physician team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended:

(a) An assistant physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

(b) No supervision requirements in addition to the minimum federal law shall be required.

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held

unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

4. An assistant physician shall clearly identify himself or herself as an assistant physician and shall be permitted to use the terms "doctor", "Dr.", or "doc". No assistant physician shall practice or attempt to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in this section and in an emergency situation.

5. The collaborating physician is responsible at all times for the oversight of the activities of and accepts responsibility for primary care services rendered by the assistant physician.

6. The provisions of section 334.037 shall apply to all assistant physician collaborative practice arrangements. To be eligible to practice as an assistant physician, a licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period. Any renewal of licensure under this section shall include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.**]**

[334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing

patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the assistant physician;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every

fourteen days a minimum of twenty percent of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances.

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians that shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the

authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

6. A collaborating physician shall not enter into a collaborative practice arrangement with more than three full-time equivalent assistant physicians. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

7. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. Such limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

8. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any assistant physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

10. No contract or other agreement shall require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The

identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.**]**

[334.038. 1. As used in this section, the following terms shall mean:

(1) "Assistant physician", a person licensed to practice under section 334.036 in a collaborative practice arrangement under section 334.037;

(2) "Department", the department of health and senior services;

(3) "Medically underserved area":

(a) An area in this state with a medically underserved population;

(b) An area in this state designated by the United States secretary of health and human services as an area with a shortage of personal health services;

(c) A population group designated by the United States secretary of health and human services as having a shortage of personal health services;

(d) An area designated under state or federal law as a medically underserved community; or

(e) An area that the department considers to be medically underserved based on relevant demographic, geographic, and environmental factors;

(4) "Primary care", physician services in family practice, general practice, internal medicine, pediatrics, obstetrics, or gynecology;

(5) "Start-up money", a payment made by a county or municipality in this state which includes a medically underserved area for reasonable costs incurred for the establishment of a medical clinic, ancillary facilities for diagnosing and treating patients, and payment of physicians, assistant physicians, and any support staff.

2. (1) The department shall establish and administer a program under this section to increase the number of medical clinics in medically underserved areas. A county or municipality in this state that includes a medically underserved area may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having such contribution matched wholly or partly by grant moneys from the medical clinics in medically underserved areas fund established in subsection 3 of this section. The department shall seek all available moneys from any source whatsoever, including but not limited to healthcare foundations to assist in funding the program.

(2) A participating county or municipality that includes a medically underserved area may provide start-up money for a medical clinic over a two-year period. The department shall not provide more than one hundred thousand dollars to such county or municipality in a fiscal year unless the department makes a specific finding of need in the medically underserved area.

(3) The department shall establish priorities so that the counties or municipalities which include the neediest medically underserved areas eligible for assistance under this section are assured the receipt of a grant.

3. (1) There is hereby created in the state treasury the "Medical Clinics in Medically Underserved Areas Fund", which shall consist of any state moneys appropriated, gifts, grants, donations, or any other contribution from any source for such purpose. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180,

the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the administration of this section.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

4. To be eligible to receive a matching grant from the department, a county or municipality that includes a medically underserved area shall:

(1) Apply for the matching grant; and

(2) Provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician or physicians for the collaborating physician or physicians and assistant physician or assistant physicians in accordance with a collaborative practice arrangement under section 334.037 to provide primary care in the medically underserved area for at least two years.

5. The department shall promulgate rules necessary for the implementation of this section, including rules addressing:

(1) Eligibility criteria for a medically underserved area;

(2) A requirement that a medical clinic utilize an assistant physician in a collaborative practice arrangement under section 334.037;

(3) Minimum and maximum county or municipality contributions to the start-up money for a medical clinic to be matched with grant moneys from the state;

(4) Conditions under which grant moneys shall be repaid by a county or municipality for failure to comply with the requirements for receipt of such grant moneys;

(5) Procedures for disbursement of grant moneys by the department;

(6) The form and manner in which a county or municipality shall make its contribution to the start-up money; and

(7) Requirements for the county or municipality to retain interest in any property, equipment, or durable goods for seven years including, but not limited to, the criteria for a county or municipality to be excused from such retention requirement.**]**

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